

**NEW JERSEY STATE DEPARTMENT OF HEALTH AND SENIOR SERVICES
OFFICE OF MANAGED CARE**

and

**NEW JERSEY STATE DEPARTMENT OF BANKING AND INSURANCE
LIFE AND HEALTH DIVISION
MANAGED CARE BUREAU**

**HMO APPLICATION FOR A NEW OR MODIFIED CERTIFICATE OF
AUTHORITY**

INTRODUCTION

This will acknowledge your request for information about how to obtain a Certificate of Authority (COA) to operate a Health Maintenance Organization (HMO) in the state of New Jersey or to modify an existing COA. The attached pages outline our regulatory requirements, based upon the New Jersey Health Maintenance Organization Act (N.J.S.A. 26:2J-1, et seq.), regulations (N.J.A.C. 8:38 1-15), and bulletins. Copies of the law can be obtained from the Department of Health and Senior Services by calling (609) 633-0660 or the Department of Banking and Insurance at (609) 292-5436.

The applicant is expected to demonstrate that each licensing requirement is met. The Commissioners' decision whether to grant a COA is based on the analysis of documents submitted. The application shall be deemed complete when all the required information is filed on forms and in the format prescribed by us, pursuant to the procedures described below.

INSTRUCTIONS

1. Two copies (three if Medicaid is involved) of the application must be submitted; one (1) copy to:

New Jersey Department of Health and Senior Services
Office of Managed Care
PO Box 360, Room 600
Trenton, New Jersey 08625-0360

and one (1) copy to:

New Jersey Department of Banking and Insurance
Life and Health Division
Managed Care Bureau
PO Box 325
20 West State Street
Trenton, New Jersey 08625-0325

if Medicaid services are involved, also submit one (1) copy to:

Department of Human Services (DMAHS)
Office of Managed Health Care
Quakerbridge Plaza
PO Box 712
Trenton, New Jersey 08625

2. A check or money order for \$100 payable to New Jersey Department of Health and Senior Services is to accompany the application.
3. Complete the application Cover Sheet and provide all narratives and documents as described in the ensuing sections. The Cover Sheet must include an original signature by the President/CEO or other responsible officer of the HMO.
4. Number each narrative and document according to the item number to which it corresponds, (e.g. II. Organization/Legal). Number each page consecutively in the upper right hand corner, throughout the filing. Tabs should be inserted indicating each of the 6 major sections of the application. All exhibits, charts, etc., should be in the appropriate section and placed in three-ring binders with identifying information on the front and the spine.
5. If the applicant is offering HMO coverage to the Individual and Small Employer Groups (2-50 employees) market, provide certification that the contracts, evidence of coverage forms and rates have been or shall be properly filed or certified pursuant to N.J.S.A. 17B:27A-1 et seq., N.J.A.C. 11:20 et. seq. N.J.A.C. 11:21-1 et seq.
6. If this is a Modification application, only provide those items that differ from your previous submission if less than one year old, accompanied by a Certification from the President/CEO (attesting to the accuracy of this assertion) that the other items are unchanged. You may reference the appropriate sections of the previous submission. If any material is more than one year old, all requested information must be filed.

**HEALTH MAINTENANCE ORGANIZATION
APPLICATION FOR A NEW OR MODIFIED CERTIFICATE OF AUTHORITY**

COVER SHEET

1. _____
Name of Health Maintenance Organization
- 1a. _____
NAIC Number
- 1b. _____
FEIN Number
2. _____
Address
3. _____
City
4. _____
County
5. _____
State
6. _____
Zip Code
7. _____
Chief Executive Officer
- 7a. _____
Telephone Number
- 7b. _____
Fax Number
- 7c. _____
E-mail
8. _____
Application Administrative Contact
- 8a. _____
Telephone Number
- 8b. _____
Fax Number
- 8c. _____
E-mail
9. _____
Application Financial Contact
- 9a. _____
Telephone Number
- 9b. _____
Fax Number
- 9c. _____
E-mail
10. Plan offered or applied for: (check all that apply)
- HMO Startup ☐
Modification ☐
11. a. Large Group (over 50) ☐
Small Group (2-50) ☐
Individual ☐
- b. Commercial ☐
Medicaid ☐
Medicare ☐
- c. Point-of-Service ☐
- d. Open Access ☐
- e. Other ☐ (Please describe in detail)

12. For-Profit ☐
Not-For-Profit ☐

13. _____
Anticipated date of operation in New Jersey or effective date of modification

14. _____
Proposed service area. List counties.

15. Will a Federal Qualification be filed? ☐ Yes ☐ No

15a. If Federally Qualified: effective date _____

15b. Which Counties? _____

16. If Competitive Medical Plan (CMP): effective date _____

16a. Which Counties? _____

17. If currently operating: date of COA in New Jersey _____

18. _____
Current commercial service area (if a modification)

19. _____
Current Medicare service area (if a modification)

20. _____
Current Medicaid service area (if a modification)

21. _____
Parent Company Name

21a. _____
Parent Contact Person

21b. _____
Telephone Number Fax Number E-mail

22. _____
Guarantor (If different from Parent)
- 22a. _____
Guarantor Contact Person
- 22b. _____
Telephone Number Fax Number E-mail

I CERTIFY that all information and statements made in this application are true, complete and current to the best of my knowledge and belief.

23. _____
Name and Title* Original Signature Date

*Must be President/CEO or other responsible senior officer.

A. General/Commercial Application

I. General Description

1. Describe the HMO's origin and structure. Include a discussion of the parent and all affiliates and their current activities. Include discussion of guarantor if other than parent or affiliate.
2. Initial applicants must provide a history of financial results over the last five years of the Capital and Surplus guarantor (GAAP audited balance sheet and Revenue and Expense Statement or 10K filing acceptable). For an expansion or modification of an existing HMO, provide a history of financial results over the last five years.

(complete NAIC exhibit A)

3. Include a mission statement and summary of a three year business plan.

II. Organization/Legal

1. Provide a copy of the Articles of Incorporation of the HMO:
 - a. if not a New Jersey corporation, submit a copy of the HMO's certificate from the Department of State certifying the HMO is registered to do business in New Jersey; (copy of form _____ attached)
 - b. submit copies of all changes filed leading to the HMO's current name.
2. Provide a copy of the Articles of Association, partnership agreement, trust agreement or other applicable documents relating to the organization of the HMO and all amendments thereto.
3. Provide a copy of the bylaws, rules or similar documents regulating the conduct of the internal affairs of the applicant.
4. Provide a list of owners of the HMO:
 - a. include only owners with a 10% or greater ownership share;
 - b. list all non-owner investors, their original level of investment and describe the structure of the investment.
5. Provide a list of Board Members (names, personal addresses and occupations/affiliations/business).
6. Provide a list of the persons who are to be responsible for the conduct of the affairs of the HMO including names, addresses, official positions and biographical affidavits (use form of exhibit B for each);

- a. include all officers and senior level personnel. (At least - CEO, MCD Director, Marketing Director and CFO).
7. Please depict the following in charts:
- a. all contractual arrangements of the health care delivery system (use form of exhibit C1);
 - b. internal management and administrative staff of the HMO (use form of exhibit C2);
 - c. identify relationships between and among the applicant and all affiliates (use form of exhibit C3).
8. Provide a list of in-force insurance covering the HMO, including where applicable:
- a. a cover note or declaration page for stop loss insurance;
 - b. a complete fully executed policy for insolvency coverage to include at a minimum:
 - 1) continuation of coverage to end of premium paying period;
 - 2) continuation of in-patient coverage to date of discharge;
 - c. a cover note or declaration page for malpractice for the HMO and employed providers;
9. Provide a copy of the approval of the Attorney General's office in the case of purchase and/or conversion from non- profit to for-profit status. Provide a detailed description of any charitable trust or similar organization established in relation to a conversion to for-profit status.
10. For an initial COA application, provide a copy of the Power of Attorney duly executed by the applicant, if not domiciled in this State, appointing the Commissioner and his or her successors in office, and duly authorized designees, as the true and lawful attorney of the applicant in and for this State upon whom all lawful process in any legal action or proceeding against the HMO on a cause of action arising in this State may be served.
11. Provide a specimen copy of provider contracts between each type of provider (e.g. physician, specialist, hospital, ancillary) and the HMO, including all referenced appendices and description of any compensation program involving incentive or disincentive payment arrangements (complete exhibit E for each type contract).

Include all variants of contracts for a particular service provider. Include copies of contracts between all sub-contracting entities and their individual participating providers.

(Note: Do Not submit signature pages to the Department of Banking and Insurance).

12. Provide copies of any contracts made or to be made between any persons listed in numbers 4, 5, and 6 (above) and the HMO.
13. Provide copies of any contract made or to be made with an insurer, a medical or health service corporation, or other entity and the HMO for the provision of administrative, claims or management services.
14. Provide a copy of the form of evidence of coverage to be issued to the subscriber. Include all versions by plan.
15. Provide a copy of the form of the large group (over 50 employees) contract and evidence of coverage forms which are to be issued to subscribers and contract holders (complete exhibit F for each such contract).
16. Provide a description of the mechanism by which members and providers will be afforded the opportunity to participate in matters of policy and operation.
17. Provide a copy of the member handbook. If final printed copies are not available, final draft or markup copies will be acceptable. Include all different member handbooks - e.g., versions as required by different purchasers of HMO coverage - Medicaid, Medicare, FGHP, SHBP, etc.
18. Provide a statement from an officer of the HMO attesting that it and all affiliated entities have been in compliance with all applicable State and Federal laws for the last 12 months.
19. Please certify as to whether or not the applicant or any affiliate has ever been penalized by any State or Federal agency and/or has ever been under special financial supervision by any State or Federal agency? If penalized or otherwise sanctioned, please provide the details of such actions against the plan.

III. Health Care Services

1. Summary description of the health care delivery systems - Overview of how health care delivery system works - include short description of how adequacy of numbers and types of providers to enrollees is achieved, how quality is monitored and improved, how under-utilization and over-utilization are controlled, how emergency/urgent care is delivered on a timely basis, how patient and provider complaints are adjudicated, and describe arrangements for assuring access to health care for "culturally and linguistically diverse" members.

2. Copies of signature pages of executed provider contracts representing all mandated basic services. There must be at least executed adult and pediatric primary care physician contracts and OB/GYN physician contracts in numbers and geographical distribution so as to assure accessibility for that number of enrollees projected for month 12 of the first year of operations. In lieu of executed contracts for specialists, secondary, tertiary hospitals and the other mandated basic services, there must be submitted letters of intent from non-contracting specialists, hospitals, etc. Please note that letters of intent cannot be substituted for primary care physicians or OB/GYN physicians. Letters of intent in lieu of missing non-pcp provider contracts should be considered as an exception to the rule - i.e., no more than three missing providers per county. In those cases the HMO must: (Note: Do not submit any signature pages to DOBI)
- a. state the reasons why it could not obtain contract(s).
 - b. explain alternative arrangements for providing care.
 - c. certify that it will continue to pursue contracts for missing providers.
 - d. submit a copy (copies) of signed letter(s) of agreement from non-contracting provider.
 - e. list name, address, phone, specialty and hospital affiliation on letter of intent from signee.
 - f. letter of intent from signees should be added to Table 2, 3, and 4 and the provider directory indicating their status by an asterisk with a statement explaining their status.
3. Directory of providers by specialty and by county. Please include provider's name, office address, phone number, specialty and hospital affiliation. Indicate whether board certified or board eligible.
4. Table 2: The numbers and types of providers by county listed on Table 2 must correspond to the numbers and types of provider contract signature pages, as well as the numbers and types of providers listed in the directory.
5. Map detailing location of primary care, frequently used specialists, and inpatient care sites. Please submit county- specific, zip coded maps accompanied by zip coded/ town-city lists with population by zip codes.
- 5A. Provide a detailed network capacity analysis for each county based on each county's projected enrollment after one year. Also include in this section the plan's standards for assuring that the numbers and types of providers keep pace with enrollment growth.

6. Continuous Quality Improvement (CQI)

- a. submit a full description, one page summary and one page flow chart of a system-wide continuous quality improvement program. The program must be under the direction of the medical director and shall include:
 - 1) description of the plan's provider credentialing policies and procedures.
 - 2) specifications of standards of care, criteria and procedures for assessing the quality, adequacy and appropriateness of health care resources utilized.
 - 3) a system of ongoing evaluation activities, including focused case reviews as well as pattern analysis.
 - 4) a system of monitoring member and provider satisfaction and feedback.
 - 5) procedures for conducting peer review.
 - 6) a system to coordinate the CQI program with other performance of monitoring activities including at least utilization management, risk management, member and provider complaints programs.
 - 7) a system to evaluate the effectiveness of the CQI program.
 - (a) describe the multidisciplinary CQI Committee and its responsibilities.
 - (b) describe the Board of Directors (BOD) involvement with the CQI program including the mechanism by which the BOD shall be apprised of all CQI activities
 - 8) a description of the plan for external quality audit.
 - 9) a description of the system to compile performance and outcome data.

7. Utilization Management (UM)

- a. submit a full description, one page summary and one page flow chart of a comprehensive utilization management program. The program must be under the direction of the medical director and shall include:
 - 1) procedures to evaluate medical necessity including written criteria and protocols used in decision making.
 - 2) mechanisms to detect underutilization and overutilization.
 - 3) outcome and process measures

- 4) **mechanism to evaluate member satisfaction with complaint system and utilization management appeals system.**
- 5) **mechanism for developing and updating clinical criteria and protocols which shall be readily available to members and providers. Describe how clinical criteria and protocols are developed with involvement from participating physicians and other licensed providers with the network.**
- b. **describe utilization management staff education and experience, and their availability.**
- c. **submit all policies and procedures for staff rendering utilization management determination.**
- d. **submit a full description, one page summary, and one page flow chart of the HMO's appeal process of utilization management determinations. The appeal process shall consist of an informal internal review by the HMO (stage 1 appeal), a formal internal review by the HMO (stage 2 appeal), and a formal external review (stage 3 appeal) by an independent utilization review organization (IURO).**
8. **Member Services - Please submit a detailed description of the Plan's member services system, including the Plan's policies and procedures regarding the implementation of member rights, along with a one page summary and flow chart of the program's major activities.**
9. **Complaint and Appeal System - Please submit a detailed description of the Plan's member and provider complaint and appeal system as outlined in N.J.A.C. 8:38-3.6, along with a one page summary and flow chart of the program's major activities.**
10. **Emergency/Urgent Care - Please submit a detailed description of how emergency/urgent medical services will be available 24 hours a day, seven days a week, along with a one page summary and flow chart of this program's major activities.**
11. **Medical Records and Source Documents - Please submit a summary description of the Plan's medical records system's policies and procedures.**

IV. Information System

1. **Provide a description of the information system used to support quality improvement and utilization management.**
 - a. **Include a description of data systems used to collect and analyze performance measures. Please identify performance measurement system used (i.e. HEDIS 3.0).**

b. Include a description of data systems used for clinical management and evaluation of clinical services.

2. Provide a description of the information systems used to support member services and member and provider complaint and appeal systems.
3. Provide a description of information systems used to credential and recredential providers.
4. Provide a description of the collection and use of encounter data. Include copy of encounter forms used and listing of data elements collected.
5. Provide a description of the methods used to verify and improve data quality. Include descriptions of procedures used to monitor data element accuracy and reliability, to oversee data input, storage, and retrieval, and to assess the completeness of data.
6. Provide a description of data security and confidentiality procedures.

V. Claims System

1. Provide an explanation of the system used to monitor the quality, accuracy, and timeliness of claim and capitation payments.
2. Describe the HMO's Open and Unreported (O&U) claim tracking system, Coordination of Benefits (COB) and reinsurance recouping systems.
3. Provide a description of how claims are tracked for timely payment in accordance with N.J.S.A. 26.2J-5.1 and associated agreements, if any, and how interest is determined if payments to providers or subscribers are late. How does a provider "prove" when his claim was submitted?
4. If applicable, provide a description of how the HMO will subrogate against third party claims.
5. If claims are to be processed by a third party, submit the contract establishing the responsibilities of all parties.

VI. Marketing

1. Provide a description of significant service area demographics by county (overall population figures, age/sex mix, social/demographic factors, etc.) which will affect enrollment. Separate for commercial, Medicare and Medicaid.
2. Provide a map of the HMO's proposed service area (new and existing if expansion application) by county, showing demographic information by three digit zip code (e.g. 086--) within the county.

3. Comment on the effect of competition among the two or three largest HMO's in the proposed counties and this HMO in terms of benefits, rates, and market penetration.
4. Provide a description of the HMO's marketing strategy including, but not limited to, use of agents, sales representatives, brokers, salaried employees or other distribution systems. Include the organizational structure for marketing. Separate individual, small group, large group, Medicare and Medicaid. Include any underwriting guidelines the HMO proposes to use in the large group market.
5. Describe system for monitoring, marketing, projections of marketing staff to assure ethical professional marketing behavior of agents.
6. Provide breakdown of the HMO's marketing budget separating commercial, Medicare, and Medicaid as follows.

a. salaries	\$ _____	\$ _____	\$ _____
b. administration/other	\$ _____	\$ _____	\$ _____
c. advertising/PR	\$ _____	\$ _____	\$ _____
d. commissions	\$ _____	\$ _____	\$ _____
e. Total Marketing Budget	\$ _____	\$ _____	\$ _____
f. Total Administrative Budget	\$ _____	\$ _____	\$ _____

7. Provide enrollment projections by county on a monthly basis for the first year of operation. These projections should be separated by line of business and must be accompanied by realistic, specific assumptions. The projections should be broken out by male/female, under age 18, 19-64, and 65 and over. For years 2 and 3 operations, provide such projections on a quarterly basis. For an expansion or modification, project both with and without the expansion and/or modification.

VII. Financial

1. Provide the most recently audited financial statements of the HMO (statutory basis; GAAP basis acceptable if no statutory audit) and parent (or affiliate if it is to be the Capital and Surplus guarantor) with accompanying notes and management letters.
2. Provide the unaudited financial statements of the HMO and parent (or affiliate) for all quarters since the last audited period including:
 - a. Balance Sheet;
 - b. Statement of Revenue and Expense;
 - c. Statement of Retained Earnings;
 - d. Statement of Cash Flows.
3. Provide financial projections monthly for the HMO for the first year and quarterly for subsequent years up to the year following "break even" but not less than three years in total. If greater than three years, also include the additional enrollment projections

in the format requested in VL6. Revenue and Expense Statement projection must be segregated and subtotaled by Commercial, Medicare and Medicaid lines of business if applicable. For expansion applications, this must be broken down into "without expansion" and "with expansion" pro forma's. Use NAIC format. Projections must include:

- 3a. Sufficient Capital to support plan to breakeven. N.J.A.C. (8:38-11.1A) (Initial)
- 3b. Net Worth Phase-In Requirements for a start-up HMO. (N.J.A.C. 8:38-11.16) (Initial)
- 3c. Minimum net worth requirement. (N.J.A.C. 8:38-11.1A) (Modification)
- 3d. Minimum insolvency deposit for administration expenses (20% of net worth between \$300k and \$1,000 adjusted annually by CPI). (N.J.A.C. 8:38-11.4A-B)
- 3e. Minimum insolvency deposit for claims. (N.J.A.C. 8:38-11.4d)
4. Provide a copy of the Capital and Surplus Guarantee in the form of exhibit G.
5. Provide a description of the assumptions used in the financial projection. These assumptions must explain every line item specifically and reasonably.
6. Provide a rate filing for each large group product which includes the following:
 - a. actuarial certification along with the PMPM cost calculation sheet;
 - b. rate relativities for each set of tiers;
 - c. projected mix of contracts;
 - d. actual premium rates;
 - e. brief explanation of the assumptions used;
 - f. trend factor;
 - g. all CRC factors (if applicable); and an
 - h. explanation of prospective experience rating (if applicable).(see exhibit H as a guide for preparation)
7. Describe in a one page summary the Plan's Financial Management Information System (FMIS) as well as the Plan's collection procedures for delinquent accounts (over 30 days).
8. Stop loss and insolvency protection - describe in detail what provisions the Plan will have in place at beginning of operations for contingency funding, and insolvency protection for its members. (Reference contract or insurance "cover notes").
9. A statement showing the source of all funding.

10. Explain any other financial control systems: check signing procedures, petty cash controls, lending policies, time tracking, purchasing policies, bank reconciliation, etc.

B. Medicare Risk/Contracts

1. Provide a copy of the Contract.
2. Provide a copy of the Evidence of Coverage.
3. Provide a copy of the rate filing.
4. Provide enrollment projections for Medicare lives broken out by male/female lives ages 65 and over, and under age 65.
5. Provider network issues - Medicare enrollment will be factored in determining adequacy of the numbers and types of providers in the plan's network.
6. Provide a copy of the cover letter to HCFA.
7. Provide a copy of the HCFA approval letter when received including a list of all counties approved.

C. Medicaid

1. Department of Human Services has its own application requirements.
2. Submit proof of fully executed contract with New Jersey Department of Human Services.
3. Medicaid enrollment will be factored in determining adequacy of the numbers and types of providers in the plan's network (enrollment provided in VI.)

D. Point-of-Service (POS)/Open Access

1. Describe any "Point-of-Service" (POS) or "Open Access" plan or plans the HMO intends to offer. Address all issues in the "Questionnaire" attached.
2. Provide the HMO POS/Open Access large group contract or rider and the associated evidence of coverage form.
 - a. Provide an executed copy of the "reinsurance type" agreement for out-of-network benefits" (if applicable); (complete entry on Exhibit D, Table 1)
 - b. Provide a copy of the group insurance contract, if using the dual contract POS approach, and the approval letter from the DOBI for such indemnity contract.

c. Provide a copy of the master group contract if using the master group contract POS approach.

3. Provide a rate filing for the HMO POS and/or Open Access plan.

(complete exhibit J).

E. Individual Health Coverage Program (IHC)/Small Employer Health Benefits Program (SEH) Boards

1. Provide a copy of the "Certificate of Compliance" filed with the New Jersey Small Employer Health Benefits Program Board.
2. For any non-standard plan, provide a copy of the contract and Evidence of Coverage, and
3. Provide the associated Rate filing.

FIVE-YEAR HISTORICAL DATA

	n-1 (most recent yr.)	n-2	n-3	n-4	n-5
Balance Sheet Items					
1. Total Assets					
2. Total Liabilities					
3. Contingency Reserve					
4. Total Net Worth					
Income Statement Items (Page 4)					
5. Premium & Related Revenue					
6. Total Revenue					
7. Total Medical and Hospital Expenses					
8. Total Administration Expenses					
9. Income (Loss)					
Enrollment					
10. Total Members at End of Period					
11. Total Member Months					
Formulas					
12. Current Ratio					
13. Other Assets / Total Assets					
14. Property and Equipment / Total Assets					
15. Total Medical & Hospice Expenses / Premium					
16. Administration Expenses / Total Revenue					
Unpaid Claims Analysis					
17. Prior Year Claims Paid During the Current Year					
18. Estimated Liability of Unpaid Claims-Previous Year					

n=Current Year (year of application or modification)

Note: Refer to current edition of NAIC HMO Annual Statement blank for source of line items listed above.